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Health Inequalities, Capitalism and the Social Economy

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Reducing health inequities is ... an ethical imperative. Social injustice is killing people on a grand scale.¹

November 21, 2016, marks the 30th anniversary of the signing of the World Health Organization (WHO)'s Ottawa Charter on Health Promotion. The Ottawa Charter was notable for reaffirming the important idea that political, economic, social, cultural, environmental, behavioural, and biological factors can all favour or harm "health," defined by the WHO as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."² Various prominent studies, both before and since that time, have revealed that health is inseparably connected to underlying political, social, and economic conditions. A range of "social determinants of health" have been identified,³ including income and income distribution; education, unemployment and job security; employment and working conditions; early childhood development; food insecurity; housing; social exclusion; social safety networks; and access to, and quality of, health services. We know, too, that Indigenous people are particularly at risk for poor health, and factors such as gender, race, and disability are also relevant in in shaping how long, and how healthy, our lives are likely to be.

Poverty and loss of community are harmful to health

At the risk of simplifying what is a highly complex issue, generally speaking, those who are well-off and live in well-off areas can expect to live longer, healthier lives than those who are poor, vulnerable, and/or suffering from unemployment. The poorer you are, the shorter and less healthy your life is likely to be. While populations have, over time, been getting healthier *overall*, health inequalities—the "preventable and unfair" differences in health status between social groups, populations, and individuals⁴—have been progressively widening in line with income inequalities since the 1970s. In its final report of 2008, the Commission on Social Determinants of Health⁵ remarked that the social distribution of health is not a natural phenomenon, but rather the result of

a "toxic combination of poor social policies and programs, unfair economics, and bad politics."

A stark illustration relates to my home city of Glasgow, UK. In one of the richest countries of the world, one quarter of Glasgow's citizens are defined as "deprived," with life expectancy gaps of up to 28 years⁶ between richest and poorest, living only a few miles apart. The fact that male life expectancy can be as low as 54 years⁷ in Glasgow's east end must indeed be the "scandal of our times."⁸ Inequalities in health must be the very worst form of injustice: "the right to life itself is at stake."⁹

Over the last 30 years, however, a number of political factors have worked to subvert the key messages of the Ottawa Charter, away from the responsibility of governments to ensure adequate income, shelter, and food for all, towards framing the problem of poor health as the consequence of freely choosing individuals making poor lifestyle choices. Blaming poor people for their own predicament is a well-worn path, and one that never seems to go out of fashion. However, a fairly well-established tradition of critical public health researchers continues to argue that it is unjust structures in society that are fundamentally to blame for health inequalities, driven by the way we organize the economy, which acts to produce and reproduce health inequalities through such social processes as alienation and exploitation. Prominent figures such as Amartya Sen, meanwhile, have recognized that health involves a complex relationship between societal structures and human agency. A particularly serious injustice, Sen suggests, is the lack of opportunity (or *capability*) that some may have to achieve good health because of their vulnerability within society, as opposed to, say, a personal decision not to worry about health in particular. Sen calls for a wider acknowledgement of the non-material dimensions of poverty, particularly "the ability to go about without shame" to be recognized as a basic human freedom. In reflecting upon health inequity in relation to his own work on capabilities and social justice, he considers that

...health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to

value. Any conception of social justice that accepts the need for a fair distribution as well as efficient formation of human capabilities cannot ignore the role of health in human life and the opportunities that persons, respectively, have to achieve good health—free from escapable illness, avoidable afflictions and premature mortality. Equity in the achievement and distribution of health gets, thus, incorporated and embedded in a larger understanding of justice.¹⁰

Indeed, people living in poverty, as well as other vulnerable or excluded groups, consistently describe the pain of being made to feel of no account, which is often experienced as more damaging than material hardship. From this perspective, inequalities (the lived experience of injustice) are not only stressful in themselves, but also greatly exacerbate the stress of coping with material deprivation.

There are arguments, too, that social cohesion is crucial to health; the better health outcomes often seen in more egalitarian societies are a consequence of stronger community life, working to mitigate against the worst of the “corrosive effects” of inequality.¹¹ This suggests that not only are solidarity and social connectedness important to health, but that other important social needs will go unmet without a larger measure of social and distributive justice. However, our present-day “market society”—where every aspect of our lives is seemingly guided by the principle of “market fundamentalism”—is not conducive to such ideals. The disruption of social unity in recent decades has proven to be remarkably toxic to our health.¹² Particularly at risk are those who are least able to negotiate or operate in markets: the poor, the elderly, the infirm, and people with disabilities.

Can the social economy help?

In recent years, and particularly since the Great Recession of 2008, however, alternative approaches to economic provisioning and social organization have increasingly been sought. Organizations operating within the “social economy” have been presented as one such alternative: using trading in the market as a means to an end—the health and well-being of individuals and communities—rather than the accumulation of wealth, and involving citizens, movements, and civil society organizations as agents or architects in the design of new social arrangements.

Many organizations operating in the social economy are small in scale, rooted in local communities and ac-

tivism, and have always been operating on the fringes of mainstream capitalism. Otherwise known as *économie sociale* in the francophone world—or the solidarity economy in Latin America—such practices are often presented as new, particularly when labelled “social enterprise” or “social entrepreneurship.” However, while certain labels come into and go out of fashion, the practices themselves are very old.

Early in the last century, for example, the Antigonish Movement was a social and economic movement that started at St. Francis Xavier University in Antigonish, Nova Scotia, Canada, following several decades of economic struggle and hardship in the province. In the 1920s, a series of programs commenced under the direction of a number of Scots-Canadian Roman Catholic priests, principally Fr. Moses Coady and Fr. J.J. (Jimmy) Tompkins, with numerous cooperatives and credit unions established across Atlantic Canada and further afield, borrowing ideas from Scots-based Robert Owen and other utopian socialists.¹³ The Antigonish Movement was, unusually, a progressive Catholic movement at a time when conservatism was dominant in the Catholic Church.¹⁴ The movement focused on adult education as a means towards social improvement and economic organization. These ideas spread across North America, and during the 1940s, a series of articles and books helped to make the movement known across Europe, Latin America, and Asia, influencing, among many other developments, the establishment of the women’s self-help movement in India, an idea that has been recently reimported to Scotland by the Church of Scotland in the form of “self-reliant groups” operating under the banner of WEvolution.¹⁵

A much more contemporary example is Unity Enterprise, an organization that started as an ecumenical partnership of churches in Glasgow just over 25 years ago. Unity Enterprise provides training, work experience, guidance and support, personal development, education, and social activities for young people and adults experiencing disabilities and/or social disadvantage. To fund its activities, the organization provides a range of goods and services, including maintenance and housing support services, community care, education, training, business partnerships, and cafés. In 2010, Unity Enterprise was awarded a contract to provide the onsite catering for those working on several construction sites of the Commonwealth Games, held in Glasgow in 2014; this provided jobs to a number of people, including those

with mental health difficulties, in the aforementioned deprived east end of Glasgow.

The results of recent research¹⁶ reaffirms the idea that to improve health and reduce health inequality, more investment needs to be directed at enhancing labour force participation, improving education, and reducing income inequality—exactly the aims of organizations such as Unity Enterprise, and, indeed, of the Antigonish Movement of almost a century ago. Organizations such as those mentioned, however, rarely see themselves as part of health systems, and may not recognize the relevance of their impact in terms of public health.

However, we know¹⁷ that such organizations can impact in various ways upon health: they can be a good mechanism for enhancing skills and employability, which leads to increased self-reliance and esteem; they can reduce stigmatization, particularly of marginalized groups; and they can work to build social capital and improve health behaviours, all of which can contribute to overall health and well-being. Their impact upon health could, in other words, be considerable. However, non-obvious public health actors such as these are rarely taken seriously by health policymakers, and their work is rarely recognized (never mind funded) for the work they perform in attempting to create a healthy society.

In conclusion, if we are serious about addressing the unequal distribution of health, then we need to become serious about shifting the balance away from focusing attention (and by far the majority of investment) on fixing people after they have become ill, and move towards action on the social determinants of health and on framing health as a question of social justice. Such a critical shift will require us to rediscover the idea that the market is a means to an end, not the end in itself; that all economies are, or should be, “social”; and that health and well-being is a product of the way that our economy and society are organized.

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1 Commission on Social Determinants of Health. *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* (Geneva: World Health Organization, 2008).

2 <http://www.who.int/about/definition/en/print.html> (accessed May 30, 2016).

3 J. Mikkonen and D. Raphael, *Social Determinants of Health: The Canadian Facts* (Toronto: York University, School of Health Policy and Management, 2010). www.thecanadianfacts.org.

4 M. Whitehead, G. Dahlgren, and L. Gilson. “Developing the Policy Response to Inequities in Health: A Global Perspective,” in T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya, and M. Wirth, eds., *Challenging Inequities in Health: From Ethics to Action* (Oxford: Oxford University Press, 2001), 309–23.

5 World Health Organization, Commission on Social Determinants of Health, *Closing the Gap in a Generation*.

6 Ibid.

7 A. Gillan, “In Iraq, life expectancy is 67. Minutes from Glasgow city centre, it’s 54,” *The Guardian*, January 21, 2006: <http://www.guardian.co.uk/society/2006/jan/21/health.politics> (accessed May 30, 2016).

8 D. Dorling, *Unequal Health: The Scandal of Our Times* (Bristol: Policy Press, 2013).

9 G. McCartney, C. Collins, M. Mackenzie, “What (or Who) Causes Health Inequalities: Theories, Evidence and Implications?” *Health Policy* 113(3):221–27.

10 A. Sen, “Why Health Equity?” *Health Economics* 11:659–66.

11 R.G. Wilkinson, *The Impact of Inequality: How to Make Sick Societies Healthier* (London: Routledge, 2005).

12 M.J. Roy and M.T. Hackett, “Polanyi’s ‘Substantive Approach’ to the Economy in Action? Conceptualising Social Enterprise as a Public Health ‘Intervention,’” *Review of Social Economy* 2016:1–23.

13 S. Dodaro and L. Pluta, *The Big Picture: The Antigonish Movement of Eastern Nova Scotia* (Montréal: McGill-Queen’s University Press, 2012); D. Lionais, “Social Enterprise in Atlantic Canada,” *Canadian Journal of Nonprofit and Social Economy Research* 6(1):25–41.

14 G. Baum, *Catholics and Canadian Socialism: Political Thought in the Thirties and Forties* (Toronto: James Lorimer, 1980).

15 C. Hill O’Connor, “The Role of Self Reliant Groups (SRGs) in Improving Individual Health and Wellbeing,” in *If Not for Profit, for What and How?* Liege, Belgium: EMES-SOCENT Conference Selected Papers, no. LG13-70, 2013. <http://www.iap-socent.be/sites/default/files/Hill%20O%27Connor%20ECSP-LG13-70.pdf> (accessed May 30, 2016).

16 L.A. Cooper, A.N. Ortega, A.S. Ammerman, D. Buchwald, E.D. Paskett, L.H. Powell, et al. “Calling for a Bold New Vision of Health Disparities Intervention Research,” *American Journal of Public Health* 105(S3):74–76.

17 M.J. Roy, C. Donaldson, R. Baker, and S. Kerr, “The Potential of Social Enterprise to Enhance Health and Well-Being: A Model and Systematic Review,” *Social Science & Medicine* 123:182–93.